

OCCUPATIONAL MEDICAL SURVEILLANCE PROGRAM PHYSICAL EXAMINATION FORM <small>(See Form ARS-182A/B for Privacy Act Notification)</small>		EMPLOYER  United States Department of Agriculture	
EMPLOYEE'S LAST NAME		FIRST NAME	SOCIAL SECURITY NO.
HEIGHT ____ Feet ____ Inches	WEIGHT ____ Pounds	PULSE ____ Beats/Min.	BLOOD PRESSURE ____
INSTRUCTIONS: Place an "X" in the appropriate box. Comment on all abnormal findings.			
General	Normal <input type="checkbox"/>	Abnormal <input type="checkbox"/>	
Skin	Normal <input type="checkbox"/>	Abnormal <input type="checkbox"/>	
Lymph Nodes	Normal <input type="checkbox"/>	Abnormal <input type="checkbox"/>	
HEENT	Normal <input type="checkbox"/>	Abnormal <input type="checkbox"/>	
Neck	Normal <input type="checkbox"/>	Abnormal <input type="checkbox"/>	
Breasts	Normal <input type="checkbox"/>	Abnormal <input type="checkbox"/>	
Lungs	Normal <input type="checkbox"/>	Abnormal <input type="checkbox"/>	
Heart	Normal <input type="checkbox"/>	Abnormal <input type="checkbox"/>	
Abdomen	Normal <input type="checkbox"/>	Abnormal <input type="checkbox"/>	
Back	Normal <input type="checkbox"/>	Abnormal <input type="checkbox"/>	
Extremities	Normal <input type="checkbox"/>	Abnormal <input type="checkbox"/>	
Genital	Normal <input type="checkbox"/>	Abnormal <input type="checkbox"/>	
Rectal	Normal <input type="checkbox"/>	Abnormal <input type="checkbox"/>	
Neurological	Normal <input type="checkbox"/>	Abnormal <input type="checkbox"/>	
IMPRESSIONS			Do Not Write In This Section <small>(For Contractor Use Only)</small>
1.			
2.			
3.			
4.			
5.			
SIGNATURE OF EXAMINING PHYSICIAN			Date <small>(Month, Day, Year)</small>